MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES
DOCUMENTATION FOR MEDICAL NEEDS FORMULA ISSUANCE

Section A. Medical Needs Formula Request – Health Care Provider Use Only

Health care provider must complete Section A and either fax or give this form to the participant to bring to the local WIC provider.

Infant Formulas:

The participant must have a medical condition determined by a physician or nurse practitioner. Additionally**, two contract formulas** must be tried, prior to issuing a non-contract brand formula.

Exempt Infant Formulas and Medical Foods:

The participant must have a medical condition that contraindicates the use of a contract infant formula as determined by a physician or nurse practitioner.

WIC Approved Contract Infant Formulas

- Enfamil LIPIL with Iron
- ProSobee LIPIL
- LactoFree LIPIL
- Gentlease LIPIL

NAME OF PARTICIPANT	DATE OF BIRTH	NAME OF PARENT/CARETAKER

PRESCRIBED FORMULA	DAILY AMOUNT [optional]	LENGTH OF TIME REQUESTED
		☐ 1 MO. ☐ 2 MO. ☐ 3 MO. ☐ 4 MO.

DIAGNOSIS ☐ GERD ☐ PREMATURITY ☐ FAILURE TO THRIVE ☐ PROTEIN ALLERGY ☐ MALABSORPTION

DESCRIBE OTHER DIAGNOSIS, REACTIONS, MEDICAL CONDITIONS AND/OR SPECIAL INSTRUCTIONS AS NEEDED:

PRINT NAME OF PHYSICIAN OR NURSE PRACTITIONER	☐ PHYSICIAN ☐ NURSE PRACTITIONER	PHONE NUMBER
SIGNATURE OF PHYSICIAN OR NURSE PRACTITIONER		DATE

SECTION B. 1. LOCAL WIC PROVIDER USE ONLY

FORMULA INTAKE HISTORY					
	FORMULA USED				
	LENGTH OF TIME	___ DAYS __ WEEKS	___ DAYS __ WEEKS	___ DAYS __ WEEKS	___ DAYS __ WEEKS
	INFORMATION REPORTED	☐ CONSTIPATION ☐ DIARRHEA ☐ GAS ☐ PROJECTILE VOMITING ☐ RASH ☐ SPITTING UP ☐ OTHER _ _________	☐ CONSTIPATION ☐ DIARRHEA ☐ GAS ☐ PROJECTILE VOMITING ☐ RASH ☐ SPITTING UP ☐ OTHER _ _________	☐ CONSTIPATION ☐ DIARRHEA ☐ GAS ☐ PROJECTILE VOMITING ☐ RASH ☐ SPITTING UP ☐ OTHER _ _________	☐ CONSTIPATION ☐ DIARRHEA ☐ GAS ☐ PROJECTILE VOMITING ☐ RASH ☐ SPITTING UP ☐ OTHER _ _________

CHECK REASON(S) FOR REQUESTING READY-TO-USE/FEED (RTU/RTF).
☐ MIXING/DILUTION DIFFICULTY ☐ PRODUCT IS ONLY AVAILABLE IN RTU/RTF
☐ POOR WATER QUALITY ☐ POOR REFRIGERATION ☐ TUBEFEEDING ☐ OTHER _________

BMI for Age OR Weight/Length [Optional]

☐ APPROVED

☐ DISAPPROVED

DATE:

MONTH(S) FORMULA APPROVED

IF DISAPPROVED, WAS HEALTH CARE PROVIDER CONTACTED? ☐ YES ☐ NO

REASON FOR DISAPPROVAL:

SIGNATURE OF APPROVAL AUTHORITY	☐ RD ☐ NUTRITIONIST ☐ RN
AGENCY NAME	AGENCY NUMBER

SECTION B.2. COMPLETE THIS SECTION WHEN LWP RECEIVES APPROVAL FROM THE STATE OFFICE.

NAME OF STATE NUTRITIONIST	DATE APPROVED	☐ Approval letter is attached with form.